

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-034383

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2468

FILED AUG 19 1963

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Winchester</u>		c. CITY OR TOWN <u>Winchester</u>	
Length of stay in 1b <u>9 years</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF, IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Manchester Nursing Home</u>		d. STREET ADDRESS (If outside, give location) <u>Home</u>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Orris</u> Middle <u>R.</u> Last <u>Fulcher</u>			4. DATE OF DEATH Month <u>8</u> Day <u>2</u> Year <u>63</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8-26-1901</u>	9. AGE (last birthday) <u>61</u>	10. IF UNDER 1 YEAR Months <u>6</u> Days <u>1</u> Hours <u>1</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction worker</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>		
11a. FATHER'S NAME <u>Maynard Fulcher</u>			11b. MOTHER'S MAIDEN NAME <u>Emma Miengniot</u>		
12a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			12b. SOCIAL SECURITY NO. <u>111-38 A</u>		
13. NAME OF HUSBAND OR WIFE <u>Dorothy Williams</u>			14. ADDRESS <u>Rt. 2 Box 191</u>		
15. NAME OF DECEASED <u>Dorothy Fulcher</u>			16. ADDRESS <u>Eureka, Missouri</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-VASCULAR DISEASE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) _____	
DUE TO (c) _____		_____	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>NONE</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year _____		

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from: <u>APRIL 8, 1963</u> to <u>AUGUST 2, 1963</u> and last saw her alive on <u>AUGUST 2, 1963</u>	
Death occurred at: <u>11:38 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE <u>B.R. Loving, M.D.</u>	22b. ADDRESS <u>BALLWIN, Mo.</u>	22c. DATE SIGNED <u>8-2-63</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8-5-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lakewood Park</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS COUNTY, Missouri</u>
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24. FUNERAL DIRECTOR <u>Schrader Home</u>	25. DATE RECD. BY LOCAL REG. <u>8-4-63</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy, M.D.</u>
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(Licensed Embalmer's Statement on Reverse Side)

DO NOT WRITE ON THIS STUB

AMENDED

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Richard Bopp

Licensed Embalmer No. 4584

P. O. Address Bellview, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.